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Behavioral Health Systems Improvement Collaborative

University of Maryland, Baltimore

History of the Collaborative

- Supported by the Mental Hygiene Administration (MHA) from Block Grant funds and state general funds
- Evolved from a longstanding training partnership between University and MHA ("Training Collaborative")
- In 2001, the partnership was expanded to include an Evidence-Based Practice Center (EBPC) and a Systems Evaluation Center (SEC) to form the "Mental Health Systems Improvement Collaborative"
- Renamed the "Behavioral Health Systems Improvement Collaborative" in 2012

Collaborative Overview

- University of Maryland, Baltimore, School of Medicine, Department of Psychiatry, Division of Services Research
- Howard Goldman, MD, PhD is the Executive Director
- The Collaborative is comprised of three centers:
  - Systems Evaluation Center (SEC)
  - Training Center (TC)
  - Evidence-Based Practice Center (EBPC)

Stakeholder Collaboration

- All three centers within the Collaborative routinely engage with other system stakeholders to improve the quality of our work. These stakeholders include:
  - Consumers
  - Family Members
  - Service Providers
  - Core Service Agencies (CSAs)
  - Other Stakeholders

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Systems Evaluation Center (SEC)

Diana C. Seybolt, Ph.D.
Director
Tim Santoni, M.A.
Data Management Administrator

Systems Evaluation Center

- Assists the MHA through:
  - Program evaluation
  - Research
  - Data analysis
  - Technical assistance
  - Consultation

Systems Evaluation Center

- The work of the SEC is used to:
  - Scientifically address key issues relevant to the system
  - Aid in administrative management of the system
  - Fulfill state and federal reporting requirements
  - Support policy change and development
  - Provide information regarding program effectiveness

SEC – Previous Projects

- Evaluation of implementation of evidence based practices
  - Supported Employment, Family Psychoeducation, Assertive Community Treatment
- Psychometric analysis of the Maryland Consumer Assessment Tool for Cultural Competence (Versions 2 and 3)
- Mental Health Transformation State Incentive Grant – state evaluators
- Consumer Quality Team (CQT) Implementation Evaluation

SEC – Current Projects

Outcomes Measurement System (OMS)

- Initiated September 2006, revised 2009
- Quantifies treatment effects of outpatient clinic services
- OMS Development Steering Committee included consumers, family members, providers, Core Service Agencies (CSAs), MHA, and other stakeholders
- Information is collected from consumers aged 6 to 64 (caregivers for younger children)
- Includes: living situation, school, psychiatric symptoms, functioning, substance use, employment, health, and legal
- Data is collected through interviews at admission and approximately every six months
- Required for authorization of outpatient services

SEC-Current Projects

OMS Data Utilization

- OMS Datamart
  - Available to the general public
  - Providers and CSAs have access to program-level data for program planning and system management
- Fulfill state and federal reporting requirements
- Submitted monthly to the Maryland StateStat program
- Used in development of State mental health budget
- Required element of the CSA Plans

SEC-Current Projects

- Development of OMS Training Materials
- Validation of the OMS Instruments
- Assertive Community Treatment (ACT)Outcomes
- Residential Rehabilitation Program (RRP) administrative data collection
- Behavioral Health Research Conference
- Presentations at national and state conferences

SEC-Current Projects

Practice Research Network(PRN)

- Collaborative project among the University of Maryland Division of Services Research, the Maryland Psychiatric Research Center (MPRC) and the VA Mental Illness Research Education and Clinical Center (MIRECC)
- Two liaisons establish networks linking CSAs, providers, and University researchers
- Currently providing participant referrals for five studies
- Developed research module for the statewide Network of Care website
- Supported by the National Institute of Mental Health (NIMH) Research Infrastructure Support Project (IP-RISP) #1R24MH082755

SEC Current Projects
Data Shorts

- Provide concise behavioral health information to various stakeholders
- Data may include PMHS, state and/or national statistics
- To receive Data Shorts, contact Susan Bradley at *Susan.Bradley@Maryland.gov*

SEC-Current Projects
Data Analysis

- SEC data analysis supports MHA system and management functions:
  - Setting reimbursement rates
  - Monitoring claims, eligibility, and outcomes data
  - Evaluating State Plan goals and objectives
  - Assist CSAs with the data section of their annual plans
  - Providing technical assistance with data, systems development
  - Developing grant/contract applications
  - Informing behavioral health integration work

SEC-Current Projects
Data Analysis

- Assist to fulfill reporting requirements:
  - Mental Health Block Grant
  - Uniform Reporting System (URS)
  - Managing for Results (MFR)
  - Client Level Data for SAMHSA
  - Consumer Perception of Care Survey (CPCS)
  - Provider Outcomes Benchmarking Project
- With MHA's permission, assist researchers with grant applications, research, and program evaluations

Thank You

For more information, please contact:

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dseybolt@psych.umaryland.edu
Tim Santoni
tsantoni@psych.umaryland.edu

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Mental Health Services Training Center

The Training Center assists the Mental Hygiene Administration (MHA) in planning, organizing and implementing conferences and training activities to support the continued growth and development of the public mental health system

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Mental Health Services Training Center

Wendy L. Baysmore, MSHSA, Assistant Director

Peggie Butler-Watson, Administrative Assistant II

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Mental Health Services Training Center

Primary Responsibility – Logistical & Financial

MHA Annual Conference

Adult Services

- Case Management
- Fire & Safety Trainings (Residential Specialists)
- TBI Trainings
- Older Adult

Child & Adolescent Annual Conference

- Resilience Training
- CSEFEL Training

Cultural Competence Conference

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Mental Health Services Training Center

Primary Responsibility – Logistical & Financial

Forensic Conference

- Regional Forums (serving Court-Involved individuals)

Office of Consumer Affairs

- LEAP Training
- WRAP Training

Special Needs Population Annual Conference

- WRAP

Suicide Annual Conference

Mental Health Services Training Center

Sponsorship, Logistical & Financial Support

- Annual MHA Psychology Conference
- Motivational Interviewing
- PMAB Review Meeting
- PMHS Stakeholders Meeting
- Person Centered Planning Training (Regionally)
- Social Security Benefits Primer: Making Employment work through work incentives
- ACT Trainings (outcomes, Introduction, supervisor collaborative, etc.)
- Screening & Assessment of Co-Occurring Disorders – Regionally
- Consumer Affairs Advisory meetings

Mental Health Services Training Center

Sponsorship Support

- SOAR Training
- CSA's Training
- Pretrial Forensic Evaluation Training
- NAMI Annual Conference
- Evidence-Based Practice Center Training

Mental Health Services Training Center

Financial Support & Contract Oversight

- Co-Occurring Disorders Supervisors Academy for DHMH
- On Our Own of Maryland Annual Conference
- On Our Own of Maryland Empowerment/Recovery Project

Mental Health Services Training Center

Technology

- **Web-Site:** http://trainingcenter.umaryland.edu
- **Webinar capability**

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Mental Health Services Training Center

FY2013 Conference/Trainings

Conference/Trainings to date: 33
Number of attendees: 2,130
Trainings by June 30, 2013: 62
Estimated number of attendees for FY2013: 3,419

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Evidence-Based Practice Center

Eileen Hansen, Director
John Coppola, Transition Age Youth Consultant/Trainer
Tom Godwin, Co-Occurring Disorders Consultant/Trainer
Meka McNeal, Supported Employment Consultant/Trainer
Bette Stewart, Assertive Community Treatment *and* Family Psychoeducation Consultant/Trainer

Evidence-Based*,Empirically Supported** and Promising ***Practices Currently Being Implemented

- Supported Employment* (SE)
- Assertive Community Treatment* (ACT)
- Family Psychoeducation* (FPE)
- Co-Occurring Disorders**
- Transition to Independence Process** (TIP)
- Person Centered Care Planning***

Eight Principles of Supported Employment

- Every interested person is eligible
- Benefits planning is offered
- Employment and mental health services are integrated
- The job search occurs rapidly
- Competitive jobs are the goal
- Client preferences are honored
- Job supports are continuous
- Employment specialists build employment networks based on client's preferences

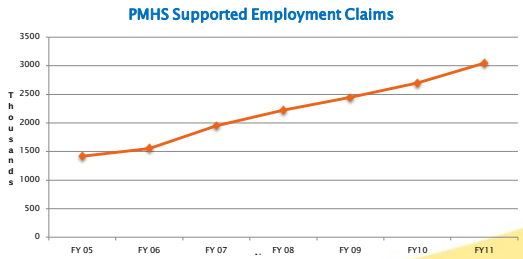
Supported Employment

- Number of programs that have been trained in Evidence-Based Practice Supported Employment since 2002 – 37;
- Number of programs currently implementing EBP SE – 25;
- The EBPC collects employment outcomes quarterly from the 25 participating EBP sites;
- January 2012 the EBPC began collecting outcomes using web based submission;
- Maryland's Efforts on Supported Employment recognized with a SAMHSA Science to Service Award 2007;
- 40% of Maryland's Mental Health Vocational Programs are Evidence-Based.

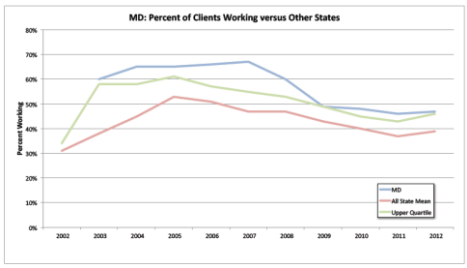
SE Outcomes - What is Collected?

- Number of people served
- Number of new enrollees in quarter
- Number of people working
- Number of new placements in the quarter
- Number participating in education programs
- Number newly enrolled in education programs in the quarter
- Number transitioned off of the case load
- Number of full-time Employment Specialists
- Number of clients on Supervisor's caseload

Demand for EBP SE services continues to grow.



Maryland Supported Employment



Assertive Community Services (ACT)

- ACT services are designed for complex-need individuals for whom traditional behavioral health services are insufficient to provide the necessary level of intensity and frequency of services;
- ACT teams provide community/home-based services using a multi-disciplinary approach, offering a wide range of services;
- Small caseloads (10:1 ratio of consumers to staff) allow ACT teams to provide frequent and intensive clinical and rehabilitative services necessary to prevent re-hospitalization, incarceration, homelessness, etc.;
- Services are provided as long as this level of intensity is necessary.

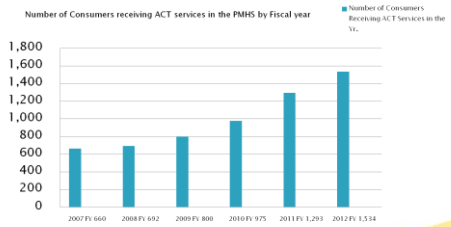
Timeline of ACT in Maryland

- The first ACT team was funded by R.W. Johnson grant in 1990 – still in operation, currently serving 115 individuals;
- In 2002, Baltimore City Core Service Agency (BMHS) received Weinberg Foundation funding to transition two mobile treatment teams (less intensive service) into ACT teams – both still in operation, currently serving 185 individuals;
- In Oct. 2003, MHA received SAMHSA Grant to develop ACT teams across the state - contracted with UMD-Evidence-Based Practice (EBP) Center to implement ACT;
- In 2004 EBP Center hired expert ACT consultant/trainer; training on ACT began;
- In 2006 MHA established an **enhanced rates** for high fidelity ACT services in order to promote this effective, cost-saving service;
- Currently 16 ACT teams have met the fidelity threshold to receive the enhanced rate; additional teams in training, with requests for training continuing.

Why is ACT Important?

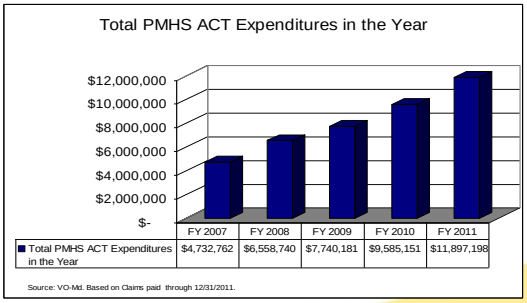
- Without ACT many individuals with high behavioral health needs would not access services;
- ACT reduces psychiatric and somatic hospitalizations and ER visits, incarcerations and illegal substance use, and promotes housing stability;
- ACT insures consumers get the appropriate level of services and support they need to recover;
- ACT services are tailored to fit consumers' goals and needs;
- ACT's trans-disciplinary team provides all services, in the community, wherever the consumer is;
- Traditional behavioral health services do not meet the needs of the population served by ACT.

Growth of ACT in Maryland



ACT PMHS Expenditures

151% increase from FY07-11



PRINCIPLES OF FAMILY PSYCHOEDUCATION

- LONG-TERM
- FOCUS ON EDUCATION, STRESS REDUCTION, SUPPORT AND WORKING TO MANAGE ILLNESS
- ORIENTED TOWARDS FUTURE, NOT PAST
- LED BY MENTAL HEALTH PRACTITIONERS
- SINGLE AND MULTIFAMILY GROUPS

Why Family Psychoeducation (FPE)?

- Most consumers have family contact or live at home.
- Mental illness creates considerable family stress.
- Family stress increases risk of relapse for consumer and increases health risks for all family members.
- Families need information about mental illness and treatment.

FPE PRINCIPLES FOR WORKING WITH FAMILIES

- Practitioners are a resource for families
- Families and consumers are equal partners with practitioners
- Recognize family strengths and encourage their use in problem solving
- Pay attention to the social as well as the clinical needs of consumers and families
- Practitioners demonstrate respect toward families and consumers

RESEARCH ON FAMILY PSYCHOEDUCATION:

- Outcome studies report a reduction of as much as 50% in annual relapse rates using this evidence-based practice.
- Studies show family members experience reduced stress, improved coping skills, greater satisfaction with care taking and fewer physical illnesses over time.
- Consumer functioning in the community improves steadily, with increased employment, better family relationships and more stable housing.

FAMILY PSYCHOEDUCATION IN MARYLAND

- Site enrollment and training began in 2002;
- Multi-family groups (MFG) include consumers and their self-identified family members;
- Multi-family groups serve five to eight families at a time, and are lead by two practitioners;
- 90% of groups run for 18 – 24 months;
- To date, twenty MFGs have served approximately 180 consumers and 250 family members.

Family Outreach Project

- MHA and NAMI are collaborators on the Johnson & Johnson--Dartmouth Community Mental Health Program's Family Outreach Project:
- Continues to provide benefits counseling to providers, family members and consumers.
- Conducted three workshops to inform vocational specialists, recipients of SSI/SSDI services and their family members about incentives; to date 103 consumers, family members and providers have attended.
- The final SSI/SSDI workshop scheduled for this fiscal year will take place in Prince George's County on June 1, targeting consumers and family members. Evidence-Based Practice Supported Employment materials are distributed at the workshops.

UMD Evidence-Based Practice Center: Maryland Initiatives to Improve Services for those with mental health and substance use (co-occurring) disorders

- National estimates suggest 50% of all individuals diagnosed with a major mental health condition will experience a problem with substance abuse during their lifetime.
- Similarly, 50% of all individuals diagnosed with a substance use disorder will experience a mental health condition at some point in their lives.
- Given the complex needs of individuals with both disorders, MHA established an expert Co-Occurring Disorders (COD) specialist at the University of Maryland Evidence-Based Practice Center in 2007.

UMD COD specialist works at all three levels of the system to develop Dual Diagnosis Capability (DDC) through Quality Improvement Initiatives:

At the State and County level –

- 3 sessions of the 14-month DHMH Co-Occurring Disorders Supervisors Collaborative completed.
- County/jurisdictional initiatives to build bridges between mental health and substance use disorders programs/providers-provide opportunities for cross training, improved collaboration and referral processes. Examples of activities:
  - **Anne Arundel County:**
    - **Consultation to both Steering Committee and Change Agent Committee**
    - **Consultation on developing the primary care physician (PCP) survey - now completed**
    - **Currently working with Change Agent Committee to develop behavioral health support materials for PCP's**
  - **Carroll County**
    - **Consultation to both Steering Committee and Change Agent Committee**
    - **Provided orientation and guidance to the two newly appointed co-chairs of Chance Agent Committee**
    - **Provided training for 100 attendees at county's behavioral health integration kickoff conference last Spring**
  - **Mid-Shore Counties**
    - **Consultation provided to behavioral health integration workgroup**
    - **Provided "brown bag" training on Person Centered Care Planning for 30 providers**
    - **Provided training/technical assistance on Dual Diagnosis Capability (DDC) Program Assessment for both addiction and mental health treatment to 50 providers representing 8 of the 9 Eastern Shore Counties**
  - **Washington County**
    - **Consultation provided to behavioral health integration workgroup**
    - **Advised the county's COD workgroup, Drug and Alcohol Council, and United Charities Project membership to meet jointly in forming a unified county behavioral health integration plan and assisted with the format of this joint planning process which is now underway**

UMD COD specialist works at all three levels of the system to develop Dual Diagnosis Capability (DDC) through Quality Improvement Initiatives:

- **At the program level –** consultation to several programs (covering all jurisdictions in the state) dedicated to learning how to provide dual diagnosis capable services. EBPC COD specialist provides training on the use of empirically supported tools (e.g. DDCAT, DDCMHT, COMPASS-EZ) and consultation to help programs assess their DDC and plan for training/quality improvement.
- **At the clinician level** – regional trainings conducted annually on screening and assessment for COD. Case-based, they address stages of change and treatment matching to enhance provider capacity to accurately assess, engage and deliver DDC services. Spring 2013 trainings already nearly full; may need to repeat quickly, given high level of interest.

UMD COD specialist works at all three levels of the system to develop Dual Diagnosis Capability (DDC) through Quality Improvement Initiatives:

- Providing training to the Substance Abuse Specialists on all of ACT teams.
- Increasingly, activities are coordinated with the Alcohol and Drug Abuse (ADAA) and Developmental Disabilities Administrations' (DDA) initiatives.
- MHA/ADAA/DDA Co-Occurring Disorders (COD) Workgroup established in 2012 to design training strategies that will enhance programs' ability to:
  - self-assess their dual diagnosis capability, using validated assessment tools
  - develop action plans for improvement
  - consultation available to programs from the EBPC COD specialist
- COD Workgroup currently exploring variety of strategies to promote dual diagnosis capability for all three administrations' programs and providers:
  - in-person training
  - teleconferences
  - web-based/online training strategies

Transition to Independence Process (TIP) Transitional Services for Youth with Mental Illnesses

- More than 3 million transition age youth have been diagnosed with a serious mental illness (Vander Stoep et al, 2000).
- Adolescents transitioning to adulthood with a serious mental illness are three times more likely to be involved in criminal activity than adolescents without an illness (Vander Stoep et all, 2000).
- Incarcerated youth age 18-22 are more likely to have a mental illness than younger adolescents in the juvenile justice system (Teplin, 1994).
- Transitional age youth with a serious mental illness have higher rates of substance abuse than any other age groups with mental illness (U.S. Department of Health and Human Services. Mental Health, 1999).

Healthy Transitions Initiative (HTI)

A five year systems change state/community partnership to create developmentally appropriate and effective youth guided/family supported local systems of care that will improve outcomes for Transition Age Youth (TAY) with mental health and co-occurring disorders in the areas of:

- employment
- education
- housing
- decrease contacts with juvenile and criminal justice systems

Goal is to effect statewide policy change and replicate effective models of service for this population.

Description of the HTI population

Transition Age Youth (TAY) between the ages of 16 to 25 with history of:

- Multiple psychiatric hospitalizations
- Residential Treatment Center (RTC) placement
- Substance abuse
- Aggressive behavior
- Behaviors resulting in danger to self or others
- Psychosis
- Poor reality testing
- High levels of impulsivity, poor judgment, and/or inability to self protect in community situations

Healthy Transitions Initiative Goals

- Provide individualized services to TAY that lead to seamless transitions, including post-school employment and/or postsecondary education;
- Enhance collaboration among Public Mental Health System and other TAY serving systems (e.g.- school systems, foster care, rehabilitation services, criminal/juvenile justice system);
- Facilitate collaboration with families and other community partners to improve service delivery and inform policy issues that effect the transition process;
- Create a statewide infrastructure that supports transition age youth/young adults;
- Improve community capacity to effectively serve TAY.

Healthy Transitions Initiative (HTI) Progress

- The project operates currently in two counties: Washington County (3 Transition Facilitators) and Frederick County (two Transition Facilitators);
- To date, approximately 154 youth have been served;
- Both communities have been operating fully staffed. Although personnel turnover has occurred, services to youth and families have been uninterrupted;
- Both community sites have dedicated, evidence based practice (EBP) Employment Specialists assigned to assist HTI youth with employment and career issues;

Healthy Transitions Initiative (HTI) Progress

- Transition Facilitators, Employment Specialists, and other key personnel in Frederick and Washington Counties have been trained in TIP and utilize practices and philosophical methodologies that contribute to youth empowerment, confidence, and self-advocacy;
- Maryland HTI continues to collaborate with existing community resources including DSS, DJJ, NAMI, On Our Own, and the Maryland Coalition of Families to support and encourage self-efficacy, self-advocacy, and community attachment;
- Youth and families provide input to all aspects of project development; family and youth are active and present on both Local Implementation Teams and the state HTI Steering Committee;
- Next Steps: Expansion of HTI service provision methodologies to MHA funded TAY programs: TIP Quality Assurance Tools purchased for use in Maryland.

Person Centered Care Planning

- Evidence-Based Practice Center in conjunction with a national expert is providing Person Centered Care Planning (PCCP) to all ACT & SE EBP providers;
- All EBP Center Trainers received on-site and teleconference training and ongoing consultation from national PCCP expert;
- National PCCP expert is providing direct training/consultation to ACT and SE programs/team leaders;
- Consumer/Peer Specialists on Assertive Community Treatment teams received same training in order to help consumers understand their enhanced role in treatment planning;
- PCCP materials customized for Traumatic Brain Injury and Older Adult populations.

Reasons for Maryland's Success

- Close collaboration between EBP Center and Mental Hygiene Administration to address system, financial and policy barriers encountered during implementation;
- Training, training, training. Given staff turnover, and natural tendency to "drift", continuous training and consultation are essential to sustain gains of these quality improvement efforts;
- Use of creative mechanisms such as Supervisors Collaboratives, Learning Communities, web-based information, etc. for flexible training/consultation .

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Evidence-Based Practice Center

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